



VVFC VACCINE ACCOUNTABILITY REPORT

PIN _____

Report Date _____

Practice _____ Contact _____

Address _____ Phone _____

_____ Fax _____

TEMPERATURES

Refrigerator

Freezer

INSTRUCTIONS:

- Record the number of doses administered to the VVFC eligible patients or free vaccine eligible patients in the middle column. You may use tally marks throughout the month; however, remember to put the numeric total in the designated column before submitting.
- Conduct a physical vaccine inventory at the close of business the last day of the month, indicating the date it was conducted. Do not include private vaccine stock. Do not list lot numbers. Estimate the number of doses in any opened, multi-dose vials. At the time of inventory, record storage temperatures in the top right-hand corner of the form.
- Any expired or wasted vaccine already reported via VVFC Return Form should not be included in the inventory.
- Obtain signature of your VVFC main contact and submit to our office.

VACCINE	DOSES ADMINISTERED (Tally Marks Optional)	TOTAL	ENDING INVENTORY Date Conducted: _____
DT (Pediatric, High Risk) <i>special order only</i>			
DTaP (Infanrix, Daptacel, Tripedia)			
DTaP-Hep B-IPV (Pediarix)			
DTaP-IPV-Hib (Pentacel)			
DTaP-Hib (Trihibit)			
DTaP-IPV (Kinrix)			
Hepatitis A (Havrix, Vaqta)			
Hepatitis B - 3 dose series (Engerix B, Recombivax)			
Hepatitis B 2-dose (Adolescent) <i>special order only</i>			
Hib (PedvaxHib, ActHib)			
Hep B-Hib (Comvax)			
HPV (Gardasil)			
Influenza TIV/injectable (Fluzone, Fluvirin)			
Influenza LAIV/intranasal (FluMist)			
IPV (Ipol)			
MCV4 - Meningococcal Conjugate (Menactra)			
MPSV4 - Meningococcal Polysaccharide <i>special order only</i>			
MMR (MMR II)			
MMR-Varicella (ProQuad)			
PCV-7 - Pneumococcal Conjugate (Prevnar)			
PPV-23 - Pneumococcal Polysaccharide <i>special order only</i>			
Rotavirus (Rotateq, Rotarix)			
Td (Akorn/Mass Biologics, Decavac)			
Tdap (Boostrix, Adacel)			
Varicella (Varivax)			
Other Vaccines:			

On behalf of myself and the practitioners associated with this facility, I agree that the data above are accurate to the best of my knowledge,

VVFC Physician Contact_____
Signature_____
Date

Division of Immunization, P.O. Box 2448
109 Governor Street, Room 314 West
Richmond, VA 23218

12/5/2008, Public & CR Facilities

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